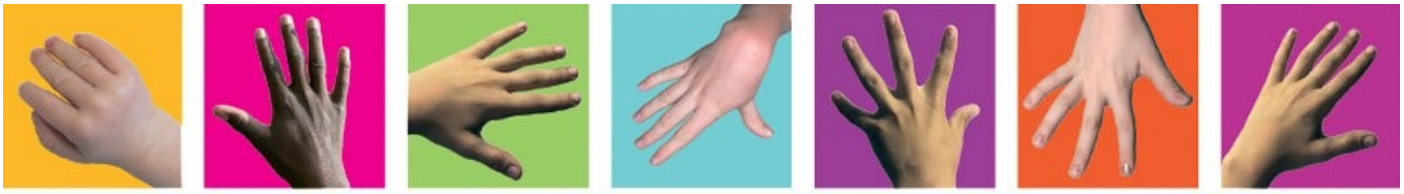


Coventry Safeguarding Children Board

Learning from Serious Case Reviews

An SCR takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. The primary aim of a SCR is to help agencies learn lessons from these events, and to use this experience to improve practice.

SCR reports can be found here.

Child E—Case Summary

Child E was 5 months old when he died in May 2014. He was found unconscious in a bed co-sleeping with his family following a party at the family home.

During this party some of the adults consumed alcohol, cocaine and cannabis. Child E remained in the lounge during this time. There were 7 other children at this party, 3 of whom were Child E's siblings.
At 4.30am mother took Child E who was already asleep, upstairs placing him in the bed between mother's brother and herself. At 9am the next morning Child E was found to be lifeless and unresponsive.
Child E was found to have a low concentration of drugs in his system, however cause of death was asphyxia.

Child E had 2 older brothers aged 2 and 3 and an older half-sister who was aged 4 at the time.
Child E's half-sister had a health condition for which she received continuing inpatient and outpatient care from Birmingham Children's Hospital. During this time her mother and stepfather participated fully in her care.

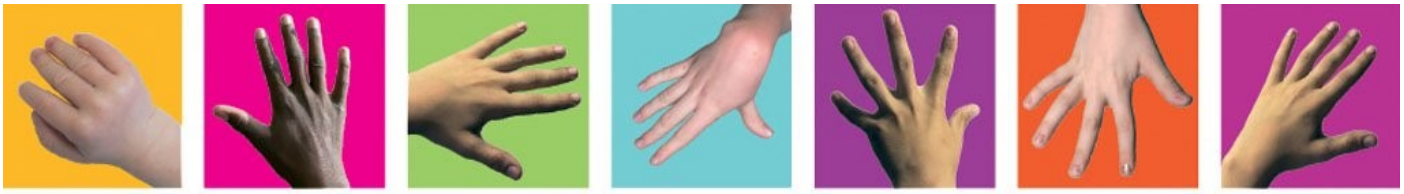
Child E's half-sister started reception class in school from Sept 2013 having attended the nursery provision linked to the school during the preceding year. Her attendance was low for 2013/14 at 48%, all absences were authorised for health reasons. The younger children did not attend any nursery or children's centre provision.

Child E's father had a number of convictions for theft and burglary; there were also offences of threats to kill, wounding, criminal damage and harassment. He had been addicted to heroin and there was a history of threats of violence and criminal damage related to his current and previous partners. He also had a history of depression and anxiety.

Mother had no previous convictions. In the main she had attended antenatal care appointments. As part of the SCR process mother said she recognised that she might have been selfish and had not always prioritised the children. She also said that she felt the dangers of co-sleeping should be brought more strongly to all parents' attention.

The family were known to routine universal health visiting services since 2009, the children were assessed as having universal needs where no additional support was required. At the last health check made Child E was doing well.

Following the death, it was discovered that cannabis was being cultivated in the loft, directly above one of the children's bedrooms. The home was dirty, smelt of urine, the bedroom that child E slept in was damp dirty and cluttered with food. There were also used nappies and unwashed clothes in piles.



Analysis

Where agencies did have contact with this family, there was little consideration of the whole family unit, including between the GP and health visiting. There was a lack of professional curiosity by Birmingham Children's Hospital who are able to provide outreach support by family support workers but there was no evidence that this was offered to the family.

In this case there were very few practitioners who had consistent contact with the family. The extent of risk and dangers of neglect were sharply brought into focus when Child E died.

There were a number of risk factors linked to neglect in respect of this family including:

- Young parents,
- Number of children that are close in age
- Worklessness
- Depression and anxiety in parents
- Children scruffy and dirty (although happy)

Key Learning

- **Early recognition of neglect**

  Better awareness and recognition of the possible indicators of neglect arising from a series of low level concerns and the cumulative way these impacts on children.

- **Authorised absence in school**

  Schools to proactively manage attendance, even when there appears to be a long-standing medical reason for the child's absence. Also utilising the support of the Children and Family First Service on issues of absences and vulnerable children.

- **Improving communication between health professionals**

  General practices managers with the primary health team should facilitate regular meetings between all health professionals involved in the delivery of care for 0 – 5 age group. This will enable regular and on-going discussion about vulnerable families and to coordinated support to vulnerable families.

- **Risk of co-sleeping**

  Continue to raise awareness of the risks of co-sleeping particularly if parents have consumed or planning to consume alcohol and/or drugs.

We encourage you to discuss this case in team meetings to understand and apply the key learning.